IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

January 5, 2009

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

Provider #13G001

Dear Ms. Broetje:

On **December 4, 2008**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003858

Allegation #1: The grievance policy is not adequate.

Findings: An unannounced on-site complaint investigation was conducted from 12/1/08 through 12/4/08. During that time, review of the facility's grievance policy, filed grievances, and staff interviews were completed with the following results:

The facility's policy on Client Complaint and Grievance, dated 10/16/08, outlined 3 phases for the client or legal guardian to file a complaint or grievance.

Phase #1 of the policy stated:
"As needed, staff will assist the client or their representative in the steps for filing the grievance. The Social Worker files the grievance and makes a copy for the team. The Social Worker assembles a 3 member team that will propose a resolution. The team forwards the proposed resolution to the Social worker. If the issue is not resolved the grievance goes to Phase 2."

Phase #2 of the policy stated:
"The Administrator appoints a Client Grievance Committee which will review the initial grievance and proposed resolution.

The committee will meet with the client to discuss reasons the original resolution was not satisfactory. The committee will propose an alternate solution. If the Grievance remains unresolved, the policy moves to phase 3."

Phase #3 of the policy stated:
"The Social Worker will offer the client an opportunity to request an Independent Review conducted by the client's choice of persons or groups. The Administrator will forward all pertinent information to the Independent Review. Recommendations from the Independent Review will be forwarded to the Administrator for review. "The recommendations of the Independent Review are not binding on {the facility}...The Administrator will determine a resolution within 5 working days and the decision will be final."

Twenty nine grievances, dated 10/17/08 through 11/30/08, were reviewed to ensure time lines were being met and grievances were resolved. Of the 29 grievances, 28 were found to be in compliance with the facility's policy.

No less than 37 direct care staff were interviewed regarding the process of filing grievances. All staff interviewed stated if a guardian or client had a complaint, they would assist the individual to complete a grievance form and turn it in to the supervisor.

Therefore, due to the lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff are not trained on the facility's abuse policy, the policy is not followed, and allegations of abuse are not investigated.

Findings: An unannounced on-site complaint investigation was conducted from 12/1/08 through 12/4/08. During that time, review of the facility's Abuse Prevention policy, investigations, and staff interviews were completed with the following results:

No less than 37 direct care staff were interviewed regarding the Abuse policy. All staff interviewed demonstrated knowledge of the policy and procedures to be followed.

Additionally, 14 allegations of abuse, neglect and or mistreatment, dated 10/17/08 through 11/30/08, were reviewed. The allegations included an Allegation Summary Form, dated 10/25/08, which stated "Administration is being neglectful by allowing {individual's name} to be victimized by peers."

The facility's Abuse Prevention policy, dated 10/1/08, defined neglect as the failure to provide goods and services necessary to avoid physical harm or mental anguish.

An example of neglect included in the policy stated "Failure to appropriately explore the reasons for, or attempt to alleviate a client's distress as a result of humiliation, threats and/or intimidation."

The policy stated if the facility's Lead Investigator received an allegation against the Administrative Director of the facility, the Lead Investigator would contact the Administrator of the Division of Family and Community Services (FACS Administrator) and follow the directions provided.

The policy stated the FACS Administrator "...will be responsible for ensure {sic} completion of the report and related paperwork." The policy stated a thorough investigation included "Interview all witnesses...Visit the scene of the incident if relevant...Review previous allegations...Review other relevant documents which may include but are not limited to nursing notes, staff communication logs, PCPs {Person Centered Plans}, behavior data, and restraint records."

The policy stated the Investigator was to make recommendations if the allegation was substantiated. The policy did not specify if the Investigator was the FACS Administrator or the facility's Lead Investigator.

When asked about the 10/25/08 Allegation Summary Form which alleged Administrator neglect, the facility's Lead Investigator stated on 12/2/08 at 2:35 p.m., an allegation against Administration was received and per policy, it was referred to the FACS Administrator.

The facility Administrator was interviewed on 12/3/08 at 11:15 a.m. The facility Administrator stated she did not know if the FACS Administrator received a copy of the Abuse Prevention policy. The facility Administrator stated she verbally informed the FACS Administrator that she (FACS Administrator) was to be contacted if there was an allegation of abuse against the facility's Administration. The facility Administrator stated she did not remember conversations with the FACS Administrator regarding types of abuse.

The FACS Administrator was interviewed on 12/3/08 at 2:34 p.m. When asked, the FACS Administrator stated she did not have a copy of the facility's Abuse Prevention policy and she had not read it. The FACS Administrator stated an Allegation Summary Form was received on 10/28/08. The FACS Administrator further stated the individual was interviewed and reported that he was afraid but staff would protect him and he had not been hurt.

The FACS Administrator then stated the allegation was investigated as she spoke with the individual's guardian, followed up with the facility Administrator, and had a meeting with other guardians present on 11/10/08.

The FACS Administrator provided a letter to the survey team, on 12/3/08, as evidence the allegation had been investigated. The letter, dated 11/18/08, documented a meeting was held on 11/10/08 to discuss the fears expressed by the individual and acknowledged it would be difficult to protect individuals from "yelling, attempted assaults, etc." However, the letter did not document that a thorough investigation had been completed, that the investigation was completed in five working days, or that appropriate corrective action had been taken in response to the allegation.

Therefore, the allegation was substantiated and deficient practice was identified at W149, W154, W156, and W157.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #3: Behavior data is not tracked.

Findings: An unannounced on-site complaint investigation was conducted from 12/1/08 through 12/4/08. During that time, review of Significant Event Reports, Minor Incident Reports, individual to individual abuse and assaults, and data related to Behavior Reporting Forms {BRF} were reviewed. Additionally, observations and staff interviews were completed with the following results:

The facility's Significant Event Reports, Minor Incident Reports, and Behavior Reporting Forms from 10/17/08 - 12/2/08 were reviewed. Those documents were compared to the facility's tracking system for individual to individual abuse and assault. No discrepancies were identified.

No less than 37 direct care staff interviewed stated maladaptive behaviors were documented on BRF. Additionally, during the course of the survey, staff were observed to document maladaptive behaviors.

Therefore, due to lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Guardians do not receive requested information.

Findings: An unannounced on-site complaint investigation was conducted from 12/1/08 through 12/4/08. During that time, review of Behavior Reporting Forms {BRFs} and staff interviews were completed with the following results:

The Administrator was interviewed on 12/3/08 from 11:15 -11:45 a.m. The Administrator stated an e-mail was received from a guardian requesting behavior data. The Administrator was unaware of any time frame for providing information but stated the goal of the facility was to provide requested information within one week. The Administrator stated it did take about a week after she received the request to provide the information as the information needed to be redacted.

The Administrator provided Behavior Reporting Forms, dated 01/1/08 through 10/22/08, that had been copied for a guardian.

Therefore, due to a lack of evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Individuals' phone calls are not tracked.

Finding: An unannounced on-site complaint investigation was conducted from 12/1/08 through 12/4/08. During that time, observations and record reviews were conducted with the following results:

During observations conducted the evening of 12/1/08, individuals were noted to be using the telephone and staff were noted to provide them with privacy.

Records for 1 of 4 individuals reviewed showed phone use was monitored due to inappropriate phone calls to 911. As per regulatory requirements, clients must have access to telephones with privacy for calls except as contraindicated by factors identified within their individual program plans.

Therefore, this allegation was substantiated, however, no deficient practice was identified.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Allegation #6: Individuals are subjected to ongoing abuse from their peers without corrective action being taken.

Findings: An unannounced on-site complaint investigation was conducted from 12/1/08 through 12/4/08.

During that time, observations, record review and interviews with individuals and staff were conducted with the following results:

Observations were conducted the evening of 12/1/08. During that time, individuals were noted to engage in maladaptive behavior toward their peers and staff were noted to intervene.

No less than 17 individuals were interviewed and reported they felt safe and stated some of their peers exhibited negative behaviors but they could go to their rooms or leave the area if they were bothered or upset. All individuals stated staff did a good job and intervened appropriately.

Individuals' records were reviewed for appropriate corrective action to maladaptive behavior. No concerns were identified.

Therefore, due to the lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: Information is released without consent.

Findings: An unannounced on-site complaint investigation was conducted from 12/1/08 through 12/4/08. During that time, correspondence and consents were reviewed with the following results:

Four individuals' records were selected for review and various correspondence was compared to consents. All reviewed correspondence was accompanied by a consent.

During an interview on 12/4/08 from 8:38 - 9:12 a.m., the facility Administrator stated the facility never sent confidential information without guardian authorization to do so.

Therefore, due to the lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #8: Individuals engage in maladaptive behavior without plans to address the maladaptive behaviors.

Findings: An unannounced on-site complaint investigation was conducted from 12/1/08 through 12/4/08.

During that time, observations, record review and staff interviews were completed with the following results:

Observations were conducted the evening of 12/1/08. During that time, individuals were noted to engage in maladaptive behavior and staff were noted to intervene.

Four individuals' records were reviewed and showed behavior plans, approved by the facility's Human Rights Committee and the individual's guardians, were in place for maladaptive behaviors.

Therefore, due to the lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

SHERRI CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

December 23, 2008

Susan Broetje
Idaho State School and Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

RE: Idaho State School And Hospital, Provider #13G001

Dear Ms. Broetje:

This is to advise you of the findings of the Complaint Survey of Idaho State School And Hospital, which was conducted on December 4, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **January 5, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by January 5, 2009. If a request for informal dispute resolution is received after January 5, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Sherri Case

SHERRI CASE, LSW, QMRP
Health Facility Surveyor
Non-Long Term Care

Michael C Case, LSW for

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/mlw DS

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey. The surveyors conducting the survey were: Sherri Case, LSW, QMRP, Team Leader Matthew Hauser, QMRP Jim Troutfetter, QMRP Monica Williams, QMRP Common abbreviations used in this report are: FACS - Family and Community Services HRC - Human Rights Committee IDT - Interdisciplinary Team IST - Intervention Strategy Team MAR - Medication Administration Record NOS - Not Otherwise Specified OPFR - Observation, Plan of Action, Follow up, Resolution PCP - Person Centered Plan QMRP - Qualified Mental Retardation Professional SER - Significant Event Report	W 000		
W 128	483.420(a)(6) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure individuals were free from unnecessary physical restraints for 1 of 3 individuals (Individual	W 128		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 128	Continued From page 1 #4) for whom restraint was used. This resulted in an individual being mechanically restrained 24 hours a day, 7 days a week without adequate justification. The findings include: 1. Individual #4's PCP, dated 10/1/08, documented a 21 year old male diagnosed with moderate mental retardation, Soto's Syndrome (intellectual impairment and behavioral problems including attention deficit hyperactivity disorder, phobias, obsessions and compulsions, tantrums, impulsive behaviors, and speech language problems), bipolar disorder type 1 depressed with psychosis, impulse control disorder, psychosis NOS, post traumatic stress disorder, borderline personality traits, gender confusion issues, and a history of colonic polyps secondary to manipulation with his finger and other foreign objects in the rectum. His PCP stated he "...does not have any type of chronic pain but continues to somaticize [sic] and distort symptoms, the majority of his complaints have proven invalid and lack objective data when assessed...he continues to seek attention whenever possible...He appears to like medical attention so he will report symptoms that at times require extensive assessment from the nurse or physician to determine what treatment is actually needed." His PCP further stated he engaged in the behaviors of pica (defined as swallowing foreign objects) and insertion (defined as inserting objects in his rectum). During an observation on 12/1/08 from 7:45 - 8:30 p.m., Individual #4 was noted to be on 1:1 supervision and was wearing hand mitts (white cotton mitts that were secured around the wrist with Velcro straps) on both hands. When asked, direct care staff stated on 12/2/08 at 2:55 p.m.	W 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 128	Continued From page 2 Individual #4 wore the mitts at all times due to his pica and insertion behavior. The staff stated they released each hand for 10 minutes every two hours and checked circulation every 30 minutes. The staff stated both mitts were removed for showering and the left mitt was removed for eating, toileting, and taking medication. The staff stated Individual #4 had been wearing the mitts for about a month. However, his Intervention Plan, dated 11/7/08, stated both hands were to be free for eating. Individual #4's records were reviewed and included the following: - A Physician's Order, dated 10/21/08 at 8:00 p.m., stated Individual #4 was to wear hand mitts at all times. - A Physician's Order, dated 10/23/08 at 2:15 p.m., documented Individual #4's Risperdal (an antipsychotic drug) was increased from 1.5 mg a day to 2 mg twice a day and supervision was increased to "two to one supervision to protect pt (patient) from pica/ingestion [unreadable] and/or insertion into various orifices." - A Physician's Order, dated 10/23/08 at 2:30 p.m., documented an Intervention Strategy Team (IST) meeting was held and Individual #4 was to wear hand mitts at all times except when eating and toileting. However, Individual #4's records did not provide documentation to justify the use of the 24 hours a day, 7 days a week mechanical restraints as follows: a. Under the section titled Functional Assessment	W 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 128	Continued From page 3 of the IST Review of Individual #4's Behavioral Support Plan, dated 10/23/08, it stated "[Individual #4] has inserted items and his own fingers into his rectum. [Individual #4] also makes several somatic (psychological distress that manifests itself as bodily ailments) complaints and some that are bizarre in nature. [Individual #4] is on 1:1 Enhanced Supervision at Arm's Length, and 1:1 Enhanced Supervision at Close Proximity when in his room. This prevents him from swallowing and inserting items that could be dangerous to him. He has Room Search and removal of items that could be dangerous to him, if he were to swallow or insert them. These items are stored in a locked cabinet. He may retrieve those items under staff supervision, and then return them to the locked cabinet when they are not in use. Mechanical restraint using hand mitts has also been used with varying degrees of success, to prevent insertion of items into his rectum. Items in his rectum represent a health hazard that could aggravate his polyps." Individual #4's records documented his previous PCP, dated 10/9/07, showed hand mitts were used in response to each allegation, attempt, or actual insertion and removed after 30 minutes. His 10/9/07 PCP also stated if he had an item he could pica, and refused to give it to staff, the hand mitts were applied. However, Individual #4's behavioral and restraint data from 1/08 - 10/22/08, did not support that the restraints had been applied as specified in his PCP as follows: The 10/23/08 IST Review showed the following monthly rates of Individual #4's use of mechanical restraints: - 1/08: 3. However, the IST Review data	W 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 128	Continued From page 4 documented 0 incidents of insertion and 2 incidents of pica. - 2/08: 0. However, the IST Review data documented 1 incident of insertion and 2 incidents of pica. - 3/08: 0. The IST Review data documented 0 incidents of insertion and pica. - 4/08: 1. However, the IST Review data documented 0 incidents of insertion and 2 incidents of pica. - 5/08: 5. However, the IST Review data documented 8 incidents of insertion and 2 incidents of pica. - 6/08: 0. However, the IST Review data documented 1 incident of insertion and 2 incidents of pica. - 7/08: 1. IST Review data documented 0 incidents of insertion and 1 incident of pica. Additionally, Individual #4's OPFR Charting Notes, dated 7/08, stated on 7/7/08, he put a key in his mouth but did not swallow it. - 8/08: 1. However, the IST Review data documented 0 incidents of insertion and 0 incidents of pica. - 9/08: 0. However, the IST Review data documented 0 incident of insertion and 4 incidents of pica. Additionally, Individual #4's OPFR Charting Notes, dated 9/08, documented 2 incidents of actual pica and 2 additional allegations of pica.	W 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 128	Continued From page 5 - 10/1/08 - 10/22/08: 0. However, the IST Review data documented 1 incident of insertion and 2 incidents of pica. Additionally, Individual #4's OPFR Charting Notes, dated 10/08, documented 4 allegations of pica and 2 allegations of insertion. The IDT's ability to determine the efficacy of the intervention would be impeded without consistent implementation and documentation of the mechanical restraint use, as specified in Individual #4's 10/9/07 PCP. b. Under the section titled Antecedents in the 10/23/08 IST Review, it stated "Although the data indicates targeted behaviors occur most frequently during the swing shift, [Individual #4] does engage in these behaviors on the day shift and Noc shift. The occurrences are less frequent during those shifts. It is hypothesized that [Individual #4] has more structured time during the day and may therefore exhibit fewer behaviors during that time." The 10/23/08 IST Review stated "[Individual #4] has exhibited an increased number of pica, insertion, and attempts and threats of inserting or swallowing foreign bodies." The IST Review stated "Immediate implementation of mechanical restraint using hand mitts at all times, and continued use of one to one enhanced supervision at arm's length and close proximity is recommended." However, Individual #4's behavioral data from 1/08 - 10/22/08, as stated on the 10/23/08 IST Review, showed the following monthly rates of Individual #4's pica and insertion behavior: - 1/08: pica 2, insertion 0.	W 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 128	Continued From page 6 - 2/08: pica 2, insertion 1. - 3/08: pica 0, insertion 0. - 4/08: pica 2, insertion 0. - 5/08: pica 2, insertion 8. - 6/08: pica 3, insertion 1. - 7/08: pica 1, insertion 0. Individual #4's OPFR Charting Notes, dated 7/08, stated on 7/7/08, he put a key in his mouth but did not swallow it. - 8/08: pica 0, insertion 0. - 9/08: pica 4, insertion 0. Individual #4's OPFR Charting Notes, dated 9/08, stated on 9/17/08, he reported that he swallowed a piece of plastic which was not substantiated by x-ray but it was passed on 9/19/08. On 9/20/08, he put a battery in his mouth but did not swallow it. On 9/22/08, he reported that he swallowed a fish hook which was substantiated per x-ray and was passed within a few days. On 9/25/08, he alleged that he swallowed a piece of metal which was not substantiated per x-ray. - 10/1/08 - 10/22/08: pica 2, insertion 1. However, 4 incidents of alleged pica, 1 incident of alleged insertion and 1 actual insertion were documented in Individual #4's OPFR Charting Notes, dated 10/08: on 10/11/08, he alleged he swallowed a cockroach which was not substantiated per nursing assessment and monitoring. On 10/13/08, he alleged that he swallowed a piece of metal which was not substantiated per x-ray. On 10/14/08, he alleged that he swallowed a tab from a soda can which	W 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 128	Continued From page 7 was not substantiated per x-ray. On 10/19/08, he alleged that he swallowed a piece of metal which was not substantiated per x-ray. Individual #4's OPFR Charting Notes, dated 10/08, also stated on 10/19/08, he alleged that he inserted a screwdriver in his rectum which was not substantiated per x-ray. On 10/21/08, he reported that he inserted a plastic fork in his rectum which was substantiated per physician assessment. The fork was removed at a local hospital that day and hand mitts were ordered to be worn at all times. Further, after the hand mitts were ordered to be worn at all times, the 10/08 OPFR Charting notes documented on 10/23/08, he alleged he inserted a metal object into his nose at the same time he swallowed a plastic fork and inserted a plastic fork in his rectum. This was not substantiated per nursing assessment. On 10/23/08, he alleged he inserted a glass pipe up his nose to his brain. This was not substantiated per nursing assessment and on 10/26/08, he alleged that he inserted a plastic spoon in his rectum which was not substantiated per physician assessment. Additionally, Individual #4's OPFR Charting Notes, dated 11/08, stated on 11/2/08, he alleged that he inserted an 8 inch stick in his penis. This was not substantiated per nursing assessment and a urinalysis test. On 11/26/08, he alleged that he inserted "something" in his rectum which was also not substantiated per nursing assessment. In summary, Individual #4's records showed he had 2 actual pica incidents (swallowed a piece of plastic on 9/17/08 and a fish hook on 9/22/08) and 1 actual insertion incident (inserted a plastic	W 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 128	Continued From page 8 fork in his rectum on 10/21/08) since 7/1/08. Investigations in to the incidents documented the following: - A 9/23/08 investigation regarding Individual #4 ingesting the fish hook (on 922/08) stated "In 2007 there were five SERs completed for ingesting foreign objects. One of those four prompted a neglect investigation which was for ingesting a fish hook. In 2008 eight SERs were completed for ingestion of foreign objects. In 2006 two investigations were completed for staff faliing to protect [Individual #4] for insertion and ingestion of foreign objects." The investigation stated "It became evident in the interviews of staff that at least one other client had his fishing tackle out during the weekend on the unit...It was also noted during interviews, the [Individual #4's] tackle box was not properly secured in the locker provided for keeping items that he could ingest away from him. Two employees [staff names] saw the tackle box out of storage and did not tell other staff about the box being out or put it away...It is sufficient to say that Client Service Unit Aspen 2 did not provide adequate supervision to protect [Individual #4] from ingesting a fish hook. Regardless of the testimony of staff that state they watch him like a hawk [Individual #4] was able to obtain and ingest a fish hook sometime between the mornings of 9/21 and 9/22." The investigation further stated, "...a similar incident occurred on 9/17/08. [Individual #4] was able to ingest a piece of glass/plastic with no 1:1 staff aware that he had ingestible item. A seperate investigation will not ensue, but the SER will be included as further evidence...that the	W 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 128	Continued From page 9 Aspen staff did not and cannot provide sufficient supervision under the current program guidelines for supervision." The conclusion of the investigation stated "...failing to follow the guidelines given or develop sufficient programmatic guidelines to protect [Individual #4], it is determined...neglect is substantiated." - An investigation, dated 10/31/08, documented Individual #4 inserted a plastic fork in his rectum while under 1:1 supervision on the evening of 10/20/08. Individual #4's interview, attached to the investigation, documented that he remembered inserting the fork. "I remember inserting the fork. I was in my room on my bed with my clothes on...I did it Monday at midnight. I don't know who the staff was, they were facing the door with their back to me." Individual #4 self reported the incident to staff on 10/21/08 and the plastic fork was removed by medical personnel at a local hospital on that day. The investigation stated "Twelve different staff were 1 to 1 with [Individual #4] during the probable time of gaining access to the item and inserting it." Staff interviews did not identify when the fork was obtained and when Individual #4 inserted it. However, staff could not have properly implemented Individual #4's Intervention Plan, dated 10/17/08, which stated 1:1 staff were to maintain visual supervision of him at all times including "...constant visual monitoring of his hands and items he may pick up" as they would have noticed the fork and/or insertion. The 10/31/08 investigation concluded that blame could not be assigned to one staff person and	W 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 128	Continued From page 10 "When the 1 to 1 supervision proved inadequate to protect [Individual #4] from harming himself a more restrictive program strategy along with new teaching strategies should have been in place...this investigator determines the finding of neglect...is substantiated." In summary, all actual incidets of pica and insertion, since, 7/1/08 were found to be due to neglect. c. The 10/23/08 IST Review also stated "On 10/22 QMRP requested two on one staff if the mechanical (mitts) restraint could not be approved. [A Physician] and [another Physician] conferred and validated the need on 10/23. With the emergency HRC approval of the use of mitts it is felt this will be safe and the use of 2 to 1 staff is unnecessary. [Individual #4] has shown a significant increase in these behaviors (see data above) which justifies the implementation of hand mitts...Emergency room visits and medical attention are [Individual #4's] primary reinforcement for these behaviors." When asked, the Clinician stated on 12/3/08 at 11:03 a.m., two to one supervision was requested but was not implemented as they were told by administrative staff that there was not enough staff. The Clinician stated they also requested Individual #4 be moved to another living unit or to have his current living unit cleaned and "sanitized." When asked, the Clinician stated less restrictive interventions were not tried prior to implementing the hand mitts on a full time basis due to the severity of Individual #4's behavior. The Administrator stated on 12/4/08 at 8:50 a.m., the hand mitts were to protect Individual #4 from life threatening incidents such as swallowing a	W 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 128	Continued From page 11 fish hook and inserting a fork. The facility failed to ensure Individual #4's pica and insertion behaviors could not be addressed by other means (two to one supervision, a change in living unit, having his current living unit cleaned and "sanitized," etc.) prior to implementing mechanical restraints, 24 hours a day, 7 days a week. On 10/21/08, after the insertion of a plastic fork into his rectum, Risperdal (an antipsychotic drug) was increased, Prozac (an antidepressant drug) was discontinued, Lexapro (an antidepressant drug) was started, and hand mitts (white cotton mitts that were secured around the wrist with Velcro straps) were implemented 24 hours a day, 7 days a week. However, Individual #4's record did not document that his previous behavior plan had been consistently implemented or that his pica and insertion behaviors could not be addressed by other means. The facility failed to ensure the use of hand mitts 24 hours a day, 7 days a week, in response to Individual #4's pica and insertion behaviors was justified.	W 128		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures, investigations, and staff interviews it was determined the facility failed to ensure policies and procedures for the prevention and detection of neglect were implemented. This	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 12 directly impacted 1 of 14 individuals (Individual #3) for whom allegations of abuse and neglect were made and had the potential to negatively impact all individuals residing at the facility (Individuals #1,#2, #4, and #6 - #78). This resulted in an allegation of neglect not being thoroughly investigated, or completed in a timely manner with appropriate corrective action. The findings include: 1. The facility's Abuse Prevention policy, dated 10/1/08, defined neglect as the failure to provide goods and services necessary to avoid physical harm or mental anguish. An example of neglect included in the policy stated "Failure to appropriately explore the reasons for, or attempt to alleviate a client's distress as a result of humiliation, threats and/or intimidation." The policy stated if the facility's Lead Investigator received an allegation against the Administrative Director of the facility, the Lead Investigator would contact the Administrator of the Division of Family and Community Services (FACS Administrator) and follow the directions provided. The policy stated the FACS Administrator "...will be responsible for ensure [sic] completion of the report and related paperwork." The policy stated a thorough investigation included "Interview all witnesses...Visit the scene of the incident if relevant...Review previous allegations...Review other relevant documents which may include but are not limited to nursing notes, staff communication logs, PCPs, behavior data, and restraint records." The policy stated the Investigator was to make recommendations if the allegation was	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 13 substantiated. The policy did not specify if the Investigator was the FACS Administrator or the facility's Lead Investigator. The facility Administrator was interviewed on 12/3/08 at 11:15 a.m. The facility Administrator stated she did not know if the FACS Administrator received a copy of the Abuse Prevention policy. The facility Administrator stated she verbally informed the FACS Administrator that she (FACS Administrator) was to be contacted if there was an allegation of abuse against the facility's Administration. The facility Administrator stated she did not remember conversations with the FACS Administrator regarding types of abuse. The FACS Administrator was interviewed on 12/3/08 at 2:34 p.m. When asked, the FACS Administrator stated she did not have a copy of the facility's Abuse Prevention policy and she had not read it. An Allegation Summary Form, dated 10/25/08, stated "Administration is being neglectful by allowing [Individual #3] to be victimized by peers." The Allegation Summary Form documented the allegation was sent to the FACS Administrator on 10/27/08. When asked, the facility's Lead Investigator stated on 12/2/08 at 2:35 p.m., an allegation against Administration was received and per policy, it was referred to the FACS Administrator. a. The policy stated it was the facility's responsibility to ensure individuals were free from abuse and neglect. The policy included definitions of physical abuse, sexual abuse and psychological abuse. The policy Procedures	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 14 section documented the investigation procedure to be followed when an allegation of neglect or abuse was received. The FACS Administrator was interviewed on 12/3/08 at 2:34 p.m. The FACS Administrator stated an Allegation Summary Form was received on 10/28/08. The FACS Administrator further stated Individual #3 was interviewed and reported that he was afraid but staff would protect him and he had not been hurt. The FACS Administrator then stated the allegation was investigated as she spoke with Individual #3's guardian, followed up with the facility Administrator, and had a meeting with other guardians present on 11/10/08. The FACS Administrator provided a letter to the survey team, on 12/3/08, as evidence the allegation had been investigated. The letter, dated 11/18/08, documented a meeting was held on 11/10/08 to discuss the fears expressed by Individual #3 and acknowledged it would be difficult to protect individuals from "yelling, attempted assaults, etc." The letter did not meet the policy's requirements of an investigation as it did not include an interview with the Program Director or the Administrator or interviews with direct care to determine if Individual #3 was being targeted by another individual without appropriate intervention. The investigation did not contain interviews with all individuals living on the unit to determine if they were aware of a peer being targeted by another peer or if they were targeted by a peer without appropriate intervention. The letter did not include any information regarding the review of any documents such as previous allegations of neglect involving Administrative staff, client to client assaults involving Individual #3, or any other relevant documents such as staff	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 15 communication logs documenting behavioral concerns regarding individuals on the unit without appropriate intervention. Further, the letter did not contain documentation Individual #3's PCP had been reviewed to identify if he had behavioral issues that would cause his peers to react to him by yelling or being assaultive toward him without appropriate intervention. The facility failed to ensure the allegation of neglect was thoroughly investigated. b. The policy stated if an allegation met criteria for investigation, an Allegation Summary Form would be completed and a written report of the investigation would be completed within five working days of the date of the allegation. The FACS Administrator was interviewed on 12/3/08 at 2:34 p.m. The FACS Administrator stated an Allegation Summary Form was received on 10/28/08 and the allegation was investigated as she spoke with Individual #3's guardian, followed up with the facility Administrator, and had a meeting with other guardians present on 11/10/08, 13 days after the allegation was made. The facility failed to ensure the investigation was completed in five working days as stated in the policy. c. The policy stated if the allegation was not substantiated, the Administrative Director was to provide direction and follow up on any performance issues or system changes that needed to occur for performance improvement. If the allegation was substantiated, the Administrative Director was to determine appropriate "action which is reasonably likely to	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 16 prevent the recurrence of abuse, exploitation, neglect or threats to the clients." The FACS Administrator was interviewed on 12/3/08 at 2:34 p.m. The FACS Administrator stated an Allegation Summary Form was received on 10/28/08 but a summary report was not written as there was no conclusion. The Administrative Director would be unable to address a system change (if the allegation was not substantiated) or determine appropriate corrective action (if the allegation was substantiated) without a final report of determination. The facility failed to ensure policies and procedures for the prevention and detection of neglect were implemented. 2. Refer to W154 as it relates to the facility's failure to ensure all allegations of neglect were thoroughly investigated. 3. Refer to W156 as it relates to the facility's failure to ensure the results of all investigations were reported within five working days. 4. Refer to W157 as it relates to the facility's failure to ensure appropriate corrective action was taken in response to alleged neglect.	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures, investigations, and staff interviews it	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 17 was determined the facility failed to ensure all allegations of neglect were investigated. This directly impacted 1 of 14 individuals (Individual #3) for whom allegations of abuse and neglect were made and had the potential to negatively impact all individuals residing at the facility (Individuals #1,#2, #4, and #6 - #78). This resulted in an allegation of neglect not being thoroughly investigated. The findings include: 1. The facility's Abuse Prevention policy, dated 10/1/08, defined neglect as the failure to provide goods and services necessary to avoid physical harm or mental anguish. An example of neglect included in the policy stated "Failure to appropriately explore the reasons for, or attempt to alleviate a client's distress as a result of humiliation, threats and/or intimidation." The policy stated if an allegation met criteria for investigation, an Allegation Summary Form would be completed and a written report of the investigation would be completed within five working days of the date of the allegation. The policy stated if the facility's Lead Investigator received an allegation against the Administrative Director of the facility, the Lead Investigator would contact the Administrator of the Division of Family and Community Services (FACS Administrator) and follow the directions provided. The policy stated the FACS Administrator "...will be responsible for ensure [sic] completion of the report and related paperwork." The policy stated a thorough investigation included "Interview all witnesses...Visit the scene of the incident if relevant...Review previous allegations...Review other relevant documents which may include but	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 18 are not limited to nursing notes, staff communication logs, PCPs, behavior data, and restraint records." The policy stated the Investigator was to make recommendations if the allegation was substantiated. The policy did not specify if the Investigator was the FACS Administrator or the facility's Lead Investigator. An Allegation Summary Form, dated 10/25/08, stated "Administration is being neglectful by allowing [Individual #3] to be victimized by peers." The Allegation Summary Form documented the allegation was sent to the FACS Administrator on 10/27/08. When asked, the facility's Lead Investigator stated on 12/2/08 at 2:35 p.m., an allegation against Administration was received and per policy, it was referred to the FACS Administrator. The facility Administrator was interviewed on 12/03/08 at 11:15 a.m. The facility Administrator stated she did not know if the FACS Administrator received a copy of the Abuse Prevention policy. The facility Administrator stated she verbally informed the FACS Administrator that she (the FACS Administrator) was to be contacted if there was an allegation of abuse against the facility's Administration. The FACS Administrator was interviewed on 12/3/08 at 2:34 p.m. The FACS Administrator stated an Allegation Summary Form was received on 10/28/08. The FACS Administrator further stated Individual #3 was interviewed and reported that he was afraid but staff would protect him and he had not been hurt. The FACS Administrator	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 19 then stated the allegation was investigated as she spoke with Individual #3's guardian, followed up with the facility Administrator, and had a meeting with other guardians present on 11/10/08. The FACS Administrator stated a summary report was not written as there was no conclusion. The FACS Administrator provided a letter to the survey team, on 12/3/08, as evidence the allegation had been investigated. The letter, dated 11/18/08, documented a meeting was held on 11/10/08 to discuss the fears expressed by Individual #3 and acknowledged it would be difficult to protect individuals from "yelling, attempted assaults, etc." The letter did not meet the policy's requirements of an investigation. The letter did not meet the policy's requirements of an investigation as it did not include an interview with the Program Director or the Administrator or interviews with direct care to determine if Individual #3 was being targeted by another individual without appropriate intervention. The investigation did not contain interviews with all individuals living on the unit to determine if they were aware of a peer being targeted by another peer or if they were targeted by a peer without appropriate intervention. The letter did not include any information regarding the review of any documents such as previous allegations of neglect involving Administrative staff, client to client assaults involving Individual #3, or any other relevant documents such as staff communication logs documenting behavioral concerns regarding individuals on the unit without appropriate intervention. Further, the letter did not contain documentation Individual #3's PCP had been reviewed to identify if he had behavioral issues that would cause his peers to react to him by yelling or being assaultive toward him without	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 20 appropriate intervention. The facility failed to ensure the allegation of neglect was thoroughly investigated.	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures, investigations, and staff interviews it was determined the facility failed to ensure the results of all investigations were reported within 5 working days. This directly impacted 1 of 14 individuals (Individual #3) for whom allegations of abuse and neglect were made and had the potential to negatively impact all individuals residing at the facility (Individuals #1,#2, #4, and #6 - #78). This resulted in an allegation of neglect not being thoroughly investigated and lacked appropriate corrective action being taken. The findings include: 1. The facility's Abuse Prevention policy, dated 10/1/08, stated if an allegation met criteria for investigation, an Allegation Summary Form would be completed and a written report of the investigation would be completed within five working days of the date of the allegation. The policy stated the FACS Administrator "...will be responsible for ensure [sic] completion of the report and related paperwork." An Allegation Summary Form, dated 10/25/08,	W 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 156	Continued From page 21 stated "Administration is being neglectful by allowing [Individual #3] to be victimized by peers." When asked, the facility's Lead Investigator stated on 12/2/08 at 2:35 p.m., an allegation against Administration was received and per policy, it was referred to the FACS Administrator. The Allegation Summary Form documented the allegation was sent to the FACS Administrator on 10/27/08. The FACS Administrator was interviewed on 12/3/08 at 2:34 p.m. The FACS Administrator stated an Allegation Summary Form was received on 10/28/08. The FACS Administrator further stated Individual #3 was interviewed and she spoke with Individual#3's guardian, followed up with the facility Administrator, and had a meeting with other guardians present on 11/10/08. The FACS Administrator stated a summary report was not written as there was no conclusion. The FACS Administrator provided a letter to the survey team, on 12/3/08, as evidence the allegation had been investigated. The letter, dated 11/18/08, documented a meeting was held on 11/10/08 to discuss the fears expressed by Individual #3 and acknowledged it would be difficult to protect individuals from "yelling, attempted assaults, etc." The meeting was held 10 days after the Allegation Summary Form was received by the Lead Investigator of the facility. It would not have been possible for the facility Administrator to have received a written report 5 days after the Allegation Summary Form was received. The facility failed to ensure all investigations were completed in a written report, within five working days.	W 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures, investigations, and staff interviews it was determined the facility failed to ensure appropriate corrective action was taken in response to alleged neglect. This directly impacted 1 of 14 individuals (Individual #3) for whom allegations of abuse and neglect were made and had the potential to negatively impact all individuals residing at the facility (Individuals #1,#2, #4, and #6 - #78). This resulted in the absence of appropriate corrective action. The findings include: 1. The facility's Abuse Prevention policy, dated 10/1/08, stated if an allegation of abuse was not substantiated, the Administrative Director was to provide direction and follow up on any performance issues or system changes that needed to occur for performance improvement. If the allegation was substantiated, the Administrative Director was to determine appropriate "action which is reasonably likely to prevent the recurrence of abuse, exploitation, neglect or threats to the clients." An Allegation Summary Form, dated 10/25/08, stated "Administration is being neglectful by allowing [Individual #3] to be victimized by peers." When asked, the facility's Lead Investigator stated on 12/2/08 at 2:35 p.m., an allegation against Administration was received and per policy, it was referred to the FACS Administrator.	W 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 157	Continued From page 23 The Allegation Summary Form documented the allegation was sent to the FACS Administrator on 10/27/08. The FACS Administrator was interviewed on 12/3/08 at 2:34 p.m. The FACS Administrator stated an Allegation Summary Form was received on 10/28/08. The FACS Administrator then stated the allegation was investigated as she spoke with Individual #3's guardian, followed up with the facility Administrator, and had a meeting with other guardians present on 11/10/08. The FACS Administrator stated a summary report was not written as there was no conclusion. The FACS Administrator provided a letter to the survey team, on 12/3/08, as evidence the allegation had been investigated. The letter, dated 11/18/08, documented a meeting was held on 11/10/08 to discuss the fears expressed by Individual #3 and acknowledged it would be difficult to protect individuals from "yelling, attempted assaults, etc." The letter showed additional off-campus programming during evening hours was proposed for Individual #3. However, it did not address the allegation of abuse against Administration. Without a determination of substantiated or not substantiated, regarding Administration being neglectful, the Administrative Director would be unable to address a system change (if the allegation was not substantiated) or determine appropriate corrective action (if the allegation was substantiated) as required by their abuse policy. The facility failed to ensure corrective action or follow up regarding an allegation of abuse by Administration was taken.	W 157		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE	W 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 278	Continued From page 24 CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure the individual's record included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior for 1 of 4 individuals (Individual #4) whose restrictive interventions were reviewed. This resulted in an individual being mechanically restrained 24 hours a day, 7 days a week. The findings include: 1. Individual #4's PCP, dated 10/1/08, documented a 21 year old male diagnosed with moderate mental retardation, Soto's Syndrome (intellectual impairment and behavioral problems including attention deficit hyperactivity disorder, phobias, obsessions and compulsions, tantrums, impulsive behaviors, and speech language problems), bipolar disorder type 1 depressed with psychosis, impulse control disorder, psychosis NOS, post traumatic stress disorder, borderline personality traits, gender confusion issues, and a history of colonic polyps secondary to manipulation with his finger and other foreign objects in the rectum. His PCP further stated he engaged in the behaviors of pica (defined as swallowing foreign objects) and insertion (defined	W 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 278	Continued From page 25 as inserting objects in his rectum). During an observation on 12/1/08 from 7:45 - 8:30 p.m., Individual #4 was noted to be on 1:1 supervision and was wearing hand mitts (white cotton mitts that were secured around the wrist with Velcro straps) on both hands. When asked, direct care staff stated on 12/2/08 at 2:55 p.m., Individual #4 wore the mitts at all times due to his pica and insertion behavior. The staff stated they released each hand for 10 minutes every two hours and checked circulation every 30 minutes. The staff stated both mitts were removed for showering and the left mitt was removed for eating, toileting, and taking medication. The staff stated Individual #4 had been wearing the mitts for about a month. However, his Intervention Plan, dated 11/7/08, stated both hands were to be free for eating. An investigation, dated 10/31/08, documented Individual #4 inserted a plastic fork in his rectum while under 1:1 supervision on the evening of 10/20/08. Individual #4's interview, attached to the investigation, documented that he remembered inserting the fork. "I remember inserting the fork. I was in my room on my bed with my clothes on...I did it Monday at midnight. I don't know who the staff was, they were facing the door with their back to me." Individual #4 self reported the incident to staff on 10/21/08 and the plastic fork was removed by medical personnel at a local hospital on that day. A Physician's Order, dated 10/21/08 at 8:00 p.m., stated Individual #4 was to wear hand mitts at all times. An additional Physician's Order, dated 10/23/08 at 2:15 p.m., documented Individual #4's Risperdal was increased from 1.5 mg a day to 2	W 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 278	Continued From page 26 mg twice a day and supervision was increased to "two to one supervision to protect pt (patient) from pica/ingestion [unreadable] and/or insertion into various orifices." A second 10/23/08 Physician's Order, documented at 2:30 p.m., an Intervention Strategy Team (IST) meeting was held and Individual #4 was to wear hand mitts at all times except when eating and toileting. The 10/23/08 IST Review also stated "On 10/22 QMRP requested two on one staff if the mechanical (mitts) restraint could not be approved. [A Physician] and [another Physician] conferred and validated the need on 10/23. With the emergency HRC approval of the use of mitts it is felt this will be safe and the use of 2 to 1 staff is unnecessary. [Individual #4] has shown a significant increase in these behaviors...which justifies the implementation of hand mitts." When asked, the Clinician stated on 12/3/08 at 11:03 a.m., two to one supervision was requested but was not implemented as they were told by administrative staff that there was not enough staff. The Clinician stated they also requested Individual #4 be moved to another living unit or to have his current living unit cleaned and "sanitized." When asked, the Clinician stated less restrictive interventions were not tried prior to implementing the hand mitts on a full time basis due to the severity of Individual #4's behavior. The Administrator stated on 12/4/08 at 8:50 a.m., the hand mitts were to protect Individual #4 from life threatening incidents such as swallowing a fish hook and inserting a fork. The facility failed to ensure Individual #4's pica and insertion behaviors could not be addressed by other means (two to one supervision, a change	W 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 278	Continued From page 27 in living unit, having his current living unit cleaned and "sanitized," etc.) prior to implementing mechanical restraints, 24 hours a day, 7 days a week. On 10/21/08, after the insertion of a plastic fork into his rectum, Risperdal (an antipsychotic drug) was increased, Prozac (an antidepressant drug) was discontinued, Lexapro (an antidepressant drug) was started, and hand mitts (white cotton mitts that were secured around the wrist with Velcro straps) were implemented on 10/21/08 for 24 hours a day, 7 days a week. The facility failed to ensure less restrictive interventions were systematically tired and proven ineffective with Individual #4 prior to increasing Risperdal, discontinuing Prozac, starting Lexapro, and implementing hand mitts on a 24 hours a day, 7 days a week basis.	W 278		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W149, W154, W156, and W157.	MM177		
MM191	16.03.11.075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W128 and W278.	MM191		

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

Susan Broetje – Administrative Director
IDAHO STATE SCHOOL AND HOSPITAL
Idaho State Developmental Center
1660 11TH Avenue North
Nampa, Idaho 83687-5000
PHONE 208-442-2812
Fax 208-467-0965
EMAIL broetjes@dhw.idaho.gov

January 27, 2009

Debbie Ransom, R.N., R.H.I.T.
Bureau Chief
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036

RE: Idaho State School and Hospital, Provider #13G001

Dear Ms. Ransom:

Enclosed you will find the Plan of Correction for W128, W149, W154, W156, W157, and W278 which were cited during the complaint survey on December 4, 2008 with revisions to W128 and W278 based on conversations of today.

If you have any questions, please call me at 442-2812 ext 700.

Sincerely,

SBroetje

Susan Broetje
Administrative Director

ew

PLAN OF CORRECTION FOR
DECEMBER 4, 2008 COMPLAINT SURVEY

TAG W128

Corrective action for examples:
Individual #4's mitts are being faded (mitts to gloves to no restraint) non-contingently over the next six days and will be removed completely by February 2, 2009. We will not use mitts or any other form of mechanical restraint contingently or non-contingently with Individual #4 at this time. We will add non-contingent attention from medical staff twice a day.

Other individuals with the potential to be affected and corrective action taken:
All clients at ISSH who engage in maladaptive behaviour could be affected by unnecessary mechanical restraint. The Client Rights Review Committee will review all programs with mechanical restraints to assure that the restraints are based on individual need and the presenting problems cannot be addressed by other means. This committee will report recommendations to the facility Administrator for any needed follow-up. The facility Administrator will approve all future proposed mechanical restraints. Policy # 01.17 behavioral restraint will be revised to reflect this new requirement.

Measures or a systemic change to ensure deficient practice does not recur: See above.

Monitoring to ensure deficient practice does not recur:
The Intervention Strategy Teams will be instructed to review approaches for reducing self-injurious behaviors to ensure that they are both sufficiently aggressive and respectful of clients' rights with a progression of interventions according to level of restrictiveness.

Date when corrective action will be completed (usually within 60 days): 3/14/9

TAG W149

Corrective action for examples and system:
The policy will be modified to clearly delineate who conducts our investigations to protect individuals from mistreatment, neglect, and abuse. In the event that the ISSH Administrative Director is accused of mistreatment, neglect, or abuse, the FACS Division Administrator acts as the ISSH Administrative Director to direct and evaluate the investigation. The investigation will be conducted by the ISSH Lead Investigator. The FACS Division Administrator has been provided with a copy of ISSH's current policy and she has been trained in her responsibilities to review the final file, make a determination, and write the final report with conclusions, including system changes and corrective actions within policy timelines. When changes in the policy are finalized, the FACS Division Administrator will be provided an updated copy of the policy. She will also be trained and given the link to our policy on the ISSH Teamsite.

Monitoring to ensure deficient practice does not recur:
The Lead Investigator will do a quarterly review of all reports of mistreatment, neglect, and abuse, and prepare a report summarizing any concerns. The report will given to the ISSH Administrative Director or the FACS Division Administrator, as applicable.

The Performance Improvement Department will do a semi-annual review of all reports of mistreatment, neglect, and abuse, and prepare a report summarizing any regulatory concerns. The report will be given to the ISSH Administrative Director or the FACS Division Administrator, as applicable.

Date when corrective action will be completed: February 2, 2009

TAG W154

Corrective action for examples and system:
The policy will be modified to clearly delineate who conducts our investigations to protect individuals from mistreatment, neglect, and abuse. In the event that the ISSH Administrative Director is accused of mistreatment, neglect, or abuse, the FACS Division Administrator acts as the ISSH Administrator to direct and evaluate the investigation conducted by the ISSH Lead Investigator. The Lead Investigator or designee will ensure that all allegations of mistreatment, neglect, and abuse are thoroughly investigated.

Monitoring to ensure deficient practice does not recur:
The Lead Investigator will do a quarterly review of all reports of mistreatment, neglect, and abuse, and prepare a report summarizing any concerns. The report will be given to the Administrative Director.

The Performance Improvement Department will do a semi-annual review of all reports of mistreatment, neglect, and abuse, and prepare a report summarizing any regulatory concerns. The report will be given to the Administrative Director.

Date when corrective action will be completed: February 2, 2009

TAG W156

Corrective action for examples and system:
The policy will be modified to clearly delineate who conducts our investigations to protect individuals from mistreatment, neglect, and abuse. In the event that the ISSH Administrative Director is accused of mistreatment, neglect, or abuse, the FACS Division Administrator acts as the ISSH Administrative Director to direct and evaluate the investigation conducted by the ISSH Lead Investigator. The Lead Investigator or designee will ensure that all allegations of mistreatment, neglect, and abuse are thoroughly investigated within timelines.

Monitoring to ensure deficient practice does not recur:
The Lead Investigator will do a quarterly review of all reports of mistreatment, neglect, and abuse, and prepare a report summarizing any concerns. The report will be given to the Administrative Director.

The Performance Improvement Department will do a semi-annual review of all reports of mistreatment, neglect, and abuse, and prepare a report summarizing any regulatory concerns. The report will be given to the Administrative Director.

Date when corrective action will be: February 2, 2009

TAG W157

Corrective action for examples and system:
The policy will be modified to clearly delineate who conducts our investigations to protect individuals from mistreatment, neglect, and abuse. In the event that the ISSH Administrative Director is accused of mistreatment, neglect, or abuse, the FACS Division Administrator acts as the ISSH Administrative Director to direct and evaluate the investigation conducted by the ISSH Lead Investigator. The Lead Investigator or designee will ensure that all allegations of mistreatment, neglect, and abuse are thoroughly investigated within timelines. This will allow the Administrative Director to take appropriate corrective action or follow-up regarding an allegation of mistreatment, neglect, or abuse in a timely manner.

Monitoring to ensure deficient practice does not recur:
The Lead Investigator will do a quarterly review of all reports of mistreatment, neglect, and abuse, and prepare a report summarizing any concerns. The report will be given to the Administrative Director.

The Performance Improvement Department will do a semi-annual review of all reports of mistreatment, neglect, and abuse, and prepare a report summarizing any regulatory concerns. The report will be given to the Administrative Director.

Date when corrective action will be: February 2, 2009

TAG W278

Refer to response for Tag W128.